

Franklin County Public Safety
ALS PROTOCOL: AM-3, AM-5, P-15(Asthma)
Asthma/COPD/Bronchospasm

E	I	P	
S	S	S	Manage Airway/Ventilate as indicated ¹ . High Flow Oxygen. ²
S	S	S	Pulse Oximetry.
S	S	S	No Severe Respiratory Distress³ give Albuterol 2.5mg nebulized -If not improved to patient's normal status, move to below.
S	S	S	Severe Respiratory Distress³ -Albuterol Nebulizer, repeat continuously if needed.
S	S	S	CPAP , if SpO2 <91% on high flow oxygen and signs of respiratory failure.
S	S	S	IV/IO NSS, Blood Draw.
	S	S	EKG Monitor, End Tidal CO2.
	S	S	Methylprednisolone 125 mg IV.
	O	O	Magnesium sulfate 2 grams IV over 20 minutes.⁴
O	O	O	Epinephrine 1:1000 give 0.3mg IM for Imminent Respiratory Failure⁵

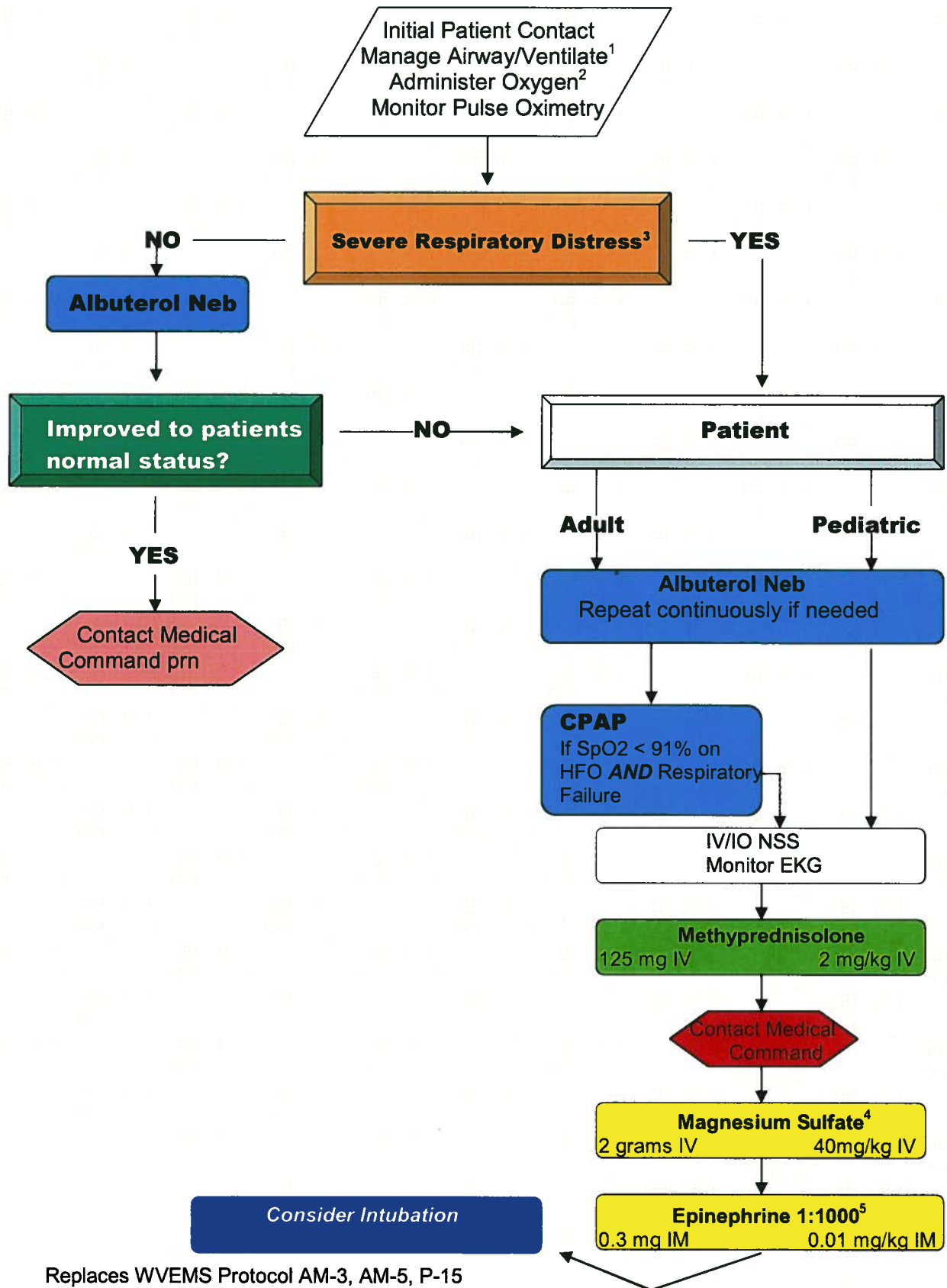
Notes:

1. **WARNING:** Although sometimes indicated, intubation may not improve ventilation since you have further narrowed the airway and increased resistance. Aggressive use of bronchodilators is generally the most important therapy.
2. Administer High Flow Oxygen to all patients in respiratory distress. COPD patients who are **NOT** in respiratory distress should receive oxygen rates sufficient to maintain SpO2 > 90%.
3. Severe Respiratory Distress generally defined by:
 - A. Apprehension, anxiety, combativeness
 - B. Hypoxia, SpO2 < 91%
 - C. Retractions, intercostal/subcostal
 - D. Nasal flaring
 - E. Cyanosis/mottling
 - F. Accessory muscle use
4. Magnesium sulfate 2 grams mixed in 50ml bag of NSS administered over 20 minutes. Rate will be 150 ml/hour or 2.5 ml/minute. Contraindicated for heart block and hypotension and dose reduced for renal failure.
5. Caution with Epinephrine because of its vasoconstrictive and proarrhythmic properties. It will be most beneficial in asthmatics and those COPD patients with a large bronchospastic component. Epinephrine should only be used in case of imminent demise of the patient's condition.

Performance Improvement Markers

- A. Documentation
 1. Lung sounds, SpO2
 2. Repeat assessments
 3. Response to treatment

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Replaces WVEMS Protocol AM-3, AM-5, P-15
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